Argonne NATIONAL LABORATORY

BLUE CROSS BLUE SHIELD OF ILLINOIS (BCBSIL)
PREFERRED PROVIDER OPTION (PPO) BENEFIT PLAN SUMMARY

Benefit	*BCBSIL PPO Network	*BCBSIL PPO Out-of-Network
Deductible, Co-Insurance and Calendar Year Out-of- Pocket Limit	$300 individual annual deductible ($600 family), then plan pays 85% of contracted rate. Calendar year out-of-pocket limit of $2000 ($4000 family) plus deductible, then plan pays 100% for the remainder of the calendar year.	$300 individual annual deductible ($600 family), then plan pays 70% of approved PPO allowance. Calendar year out-of-pocket limit of $2000 ($4000 family) plus deductible, then plan pays 100% of approved PPO allowance for the remainder of the calendar year.
General Hospital Admission	85% of contracted rate after deductible.	After deductible, 70% of most common semi-private room rate.
In-Hospital Services, Supplies, and Anesthesiology	85% of contracted rate after deductible.	70% of approved PPO allowance after deductible.
Out-Patient Surgery In-Patient Surgery	85% of contracted rate after deductible. 85% of contracted rate after deductible.	70% of approved PPO allowance after deductible. 70% of approved PPO allowance after deductible.
Out-Patient X-Ray and Laboratory	85% of contracted rate after deductible.	70% of approved PPO allowance after deductible.
Emergency Care	85% of contracted rate after deductible.	85% of approved PPO allowance after deductible.
Physicians Visits: In-Hospital, Office Visits, and Consultations	85% of contracted rate after deductible.	70% of approved PPO allowance after deductible.
Routine Vision Care	Not covered, but program through Davis Vision allows discounts on eye exams, glasses and contacts. Call 1-877-393-8844 for a list of participating providers.	Not covered, but program through Davis Vision allows discounts on eye exams, glasses and contacts. Call 1-877-393-8844 for a list of participating providers.
Routine Annual Physicals , Immunizations and Tests (not covered unless listed below) • Well Child Care Under Age 3 and Immunizations • Preventive Care Woman-Exam, Pap and Mammogram • Preventive Care Man-Exam and PSA Test • Colorectal Cancer Screening • Human Papilloma Virus Vaccine (HPV) for females ages 11-17.	 85% of contracted rate after deductible. 85% of contracted rate after deductible. Visit does not include tests other than pap, mammogram or PSA with preventive care exams. 85% of contracted rate after deductible for fecal occult blood test based on cancer screening guidelines 85% of contracted rate after deductible for test, vaccine and office visit.	 70% of approved PPO allowance after deductible. 70% of approved PPO allowance after deductible. Visit does not include tests other than pap, mammogram or PSA with preventive care exams. 70% of approved PPO allowance after deductible for fecal occult blood test based on cancer screening guidelines 70% of approved PPO allowance after deductible for test, vaccine and office visit.

*Expenses for network and out-of-network medical services are combined for individual annual maximums.

PPO BENEFIT PLAN SUMMARY (CONTINUED)

Benefit	*BCBSIL PPO Network	*BCBSIL PPO Out-of-Network
Home Health Care	85% of contracted rate after deductible up to 40 days per calendar year.	70% of approved PPO allowance after deductible to 40 days per calendar year.
Skilled Nursing Facility	85% of contracted rate after deductible of most common semi-private room rate up to 60 days in a calendar year.	70% of approved PPO allowance after deductible of most common semi-private room rate up to 60 days in a calendar year.
Hospice Care	85% of contracted rate after deductible.	70% of approved PPO allowance after deductible.
Mental Health and Substance Abuse	85% of contracted rate after deductible.	70% of approved PPO allowance after deductible.
Medical Services	Pre-certification required prior to hospitalization or within 48 hours of emergency admission. Case management.	Pre-certification required prior to hospitalization or within 48 hours of emergency admission. Case management.
Delta Dental PPO Dental Plan for Argonne employees *Deductible and out-of-pocket maximums separate from Medical and Prescription Drug Plans.* In-network includes PPO or Premier. PPO provider accepts discounted rates and Premier provider agrees not to charge over allowed amount.	$100 individual annual deductible, $300 family; plan pays 75%, patient 25% for dental work. Diagnostic and preventive services paid at 100% of contracted rate each calendar year includes 2 cleanings and exams, 2 bite-wing x-rays, 1 fluoride treatment. 1 complete full mouth x-ray allowed in 36 month interval. Calendar year maximum per person $2000. $2000 lifetime orthodontic benefit.	$100 individual annual deductible, $300 family; plan pays 75%, patient 25% for dental work. Diagnostic and preventive services paid at 100% of allowed amount each calendar year includes 2 cleanings and exams, 2 bite-wing x-rays, 1 fluoride treatment. 1 complete full mouth x-ray allowed in 36 month interval. Calendar year maximum per person $2000. $2000 lifetime orthodontic benefit.
Prescription Drug Plan *Deductible and co-insurance maximums separate from Medical and Dental Plans.*	No deductible for prescription drugs. Annual out of pocket maximum for retail drugs $1500/person, $3000/family. **Retail 30 day supply:** **Generic**: 20% (minimum $10) **Brand:** 25% (minimum $20) **Retail 90 day supply:** **Generic:** $25 **Brand:** $55 **Mail Order 90 day supply:** **Generic**: $20 **Brand:** $50 Annual out of pocket maximum does not apply on Retail 90 or mail order. **Specialty Drugs:** $20% with separate maximum of $750/person, $1500/family. **When generic drug is available, participant must use generic or pay cost difference along with brand co-pay for both retail and mail order.**	No deductible for prescription drugs. Annual out of pocket maximum for retail drugs $1500/person, $3000/family. **Retail 30 day supply:** **Generic**: 20% (minimum $10) **Brand:** 25% (minimum $20) **Retail 90 day supply:** **Generic:** $25 **Brand:** $55 **Mail Order 90 day supply:** **Generic**: $20 **Brand:** $50 Annual out of pocket maximum does not apply on Retail 90 or mail order. **Specialty Drugs:** $20% with separate maximum of $750/person, $1500/family. **When generic drug is available, participant must use generic or pay cost difference along with brand co-pay for both retail and mail order.**

*Expenses for network and out-of-network medical services are combined for individual annual maximums.